

REQUEST FOR EXTENDED SASS SERVICES

Date of request: _____ LAN#: _____
SASS AGENCY: _____
SASS AGENT: _____
SASS Phone #: _____
SASS Fax #: _____
RIN#: _____

FOR STATE DEPT USE ONLY

Approved: _____ Denied: _____ # of Days _____
Extension Date Begin: _____
Extension Date End: _____
Date Faxed: _____
Reason: _____

DCFS Ward: Y N DCFS#: _____ DOB: _____ AGE: _____
Clients Name: _____ Address: _____

****IF HOSPITALIZED IN PAST 30 DAYS****

****COMPLETE HOSPITAL INFORMATION ONLY – NO CSPI NECESSARY****

HSI ENTRY #: _____ Hospital Name: _____
Date of Admission: _____ Discharge Date (actual/anticipated): _____

FAX EXTENSION REQUEST FORM WITH CURRENT AND ALL CSPI FORMS TO:
SASS EXTENSION REVIEW TEAM
C/O CHILD AND ADOLESCENT NETWORK
FAX REQUEST TO 773-794-4881

****IF NOT HOSPITALIZED, COMPLETE BELOW****

List all SASS and all Community Mental Health Agencies to be listed as referrals with extension:

LAN#: _____
LAN#: _____
LAN#: _____

Is client on any waiting lists? Y N If yes, provide information: _____

DIAGNOSIS (please list by name):

Axis I: _____ Axis III: _____

Axis II: _____ Axis IV: _____

Axis V: _____

MEDICATION: _____

Psychiatrist: _____ Phone: _____

Client Name: _____

REASON FOR EXTENSION

(Indicate SASS services already implemented and current at-risk behaviors. Include the duration and frequency of each service.):

DESCRIBE ANY NON-SASS SERVICES CURRENTLY UTILIZED OR PLANNED

(indicate the agent providing the service, duration, frequency and/or date referred):

DESCRIBE THE CLIENT SERVICE PLAN FOR THE REQUESTED EXTENSION

(indicate the agent responsible for the provision of each service and timeframe necessary to complete the task.):
